UNITED STATES OF AMERICA
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	
THIS DOCUMENT RELATES TO: Track Three Cases	Case No. 1:17-MD-2804
	Honorable Dan A. Polster

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TRANSCRIPT OF DAUBERT HEARING VIA ZOOM PLATFORM

BEFORE JUDGE DAN A. POLSTER, JUDGE OF

SAID COURT, ON FRIDAY, SEPTEMBER 10TH, 2021,

COMMENCING AT 9:30 O'CLOCK A.M.

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I N D E X

PROCEEDINGS

THE COURT: All right. This is a Daubert hearing in MDL 2804, the Track Three case that is set to go to trial the end of this month. I requested to ask some questions of Dr. Anna Lembke, who is one of the Plaintiffs' witnesses, and the Defendants had filed a Daubert motion challenging some or all of Dr. Lembke's proposed testimony.

My plan is that I will conduct most of the questioning because I am the one who is going to have to make a decision, and I think I know the questions I have. I have got several areas I am going to cover.

And then, when I complete an area, I will allow some brief questioning by the Plaintiffs and with one counsel for the Plaintiffs and one counsel for the Defendants, and then I will move on to another area.

I have got a hard stop at 11:30, so this is not going to drag on. I want to focus on the areas that are of my concern. So focusing on the screen, do we have Dr. Lembke?

JUDICIAL ASSISTANT: Your Honor, she is in the waiting room. I was just waiting for you to take the bench. I will admit her now. One moment.

THE COURT: Okay. I just want --

JUDICIAL ASSISTANT: Your Honor, Dr. Lembke

is now in the meeting with a white background.

Dr. Lembke, if you could just say hello?

THE COURT: Oh, right in the center. Fine. Thank you, Doctor.

And I appreciate your getting up so early. When I had scheduled this, I was not focusing on the fact we might have witnesses on the West Coast. So thank you very much. So I need to swear you in, so if you could raise your right hand, please?

DR. ANNA LEMBKE

called as a witness by and being first duly sworn, was examined and testified as follows:

EXAMINATION BY THE COURT

THE COURT: All right. Thank you.

BY THE COURT:

Q. All right. Starting with a general question, Doctor, in your role as a physician, do you regularly interact with pharmacists? So I would like you to describe how and what those interactions entail and how often you interact with pharmacists.

A. Yes. I regularly interact with pharmacists. I interact with pharmacists on multiple times, on most clinic days, which constitute currently about half of the days in my week but through various points in my career constituted every work day, Monday through Friday.

On any given day, I will interact with pharmacists typically by phone. Multiple times in a day around the prescription with the advent of the electronic medical records, I also have many interactions, probably on the order of 10 to 20 interactions electronically with pharmacists.

Over the past two decades those interactions have qualitatively and quantitatively changed vis-a-vis opioid prescribing, but I can give you an example of an interaction I had with a pharmacist on Tuesday to give you a real-time example of an interaction.

Q. That would be helpful. Thank you.

A. Okay. So on Tuesday, I got a call from a pharmacist leaving a message on my phone letting me know that she was concerned about an opioid prescription for buprenorphine. Trade name is Suboxone. Under my name, she had received a call from somebody calling in the prescription and giving my DEA number and my name but was obviously a male voice?

And so she took the prescription, but then, after hanging up with that person called me and left a message and said "can you just verify this is, indeed, a real and true prescription from you?"

So I called her back, and I asked the name of the patient and when it was called in, and I let her

know that I had not made that phone call, and that I was concerned, and that I appreciated she had called me about that, and that I thought there was a possibility I thought it was one of my fellows who had used my DEA instead of his DEA, and that she should not dispense until I investigate it further.

I touched base with my fellow who is new here to the Clinic and has not yet gotten his DEA and said it was, indeed, him and that he had called it in under my DEA.

So I then called her back and said it is okay to dispense. That is a patient of ours. He is switching pharmacies because he is moving. I was aware that he had been moving?

But he is a person with severe opioid use disorder, and people can relapse at any point in their trajectory, even though he has been in recovery for several years knew?

And then I thanked the pharmacist for doing her due diligence and confirming that it was, indeed, a legitimate prescription. So that is one example of the kinds of interactions I will have with pharmacists.

I am having many more of those kind of interactions around opioid dispensing and double checking for red flags around opioid dispensing in the past two to

five years than I had prior to that, so it is good to see there is a see-change happening.

Q. All right. So your interactions with pharmacists in your practice generally center around particular prescriptions that you prescribed, either you are contacting them or like in the example you just cited, when they received a prescription purportedly from you to double check it?

A. Yes.

Q. That's the way your interactions -- okay. That's what I thought.

Let me follow up on what you just said. You said that there has been a see change in the last two to five years around interactions pertaining to prescriptions for opioids.

Will you elaborate on that a little more, please?

A. Yes. So in our clinic, we made checking the PDMP prior to checking a controlled substance mandatory around 2013, and once we started doing that, we saw many instances of, for example, doctor shopping, patients going around to multiple prescribers to get the same or a similar prescription.

We also saw examples of pharmacy shopping, patients going to various pharmacies to try to obtain

additional opioids, and we then would call the pharmacies and alert them to this problem when we encountered it as well as other red flags that we were concerned about?

And it was very seldom in that time period that we heard from pharmacists regarding these types of problems that we were detecting when we checked our prescription drug monitoring database or when we detected other red flags.

Of course, to some extent, we are prohibited by privacy laws from sharing too much with anybody outside of our clinical care. So there were instances when we were concerned but could not necessarily communicate that with pharmacists unless it was around a specific prescription.

Q. Well, I thought your interactions with pharmacists only revolved around particular prescriptions?

A. Yes. My interactions with pharmacists and interactions in general and physicians pertain to the prescriptions that we write for the patient, but in checking the prescription drug monitoring database, what we can see is all the prescriptions for controlled substances that that individual is receiving, which can raise red flags with you, which we can't necessarily discuss with a pharmacist, unless it is our specific prescription that is the prescription of concern.

Q. Okay. So you are saying starting in 2013 you were -- it was mandatory to check the PDMD. I think, Doctor, you said that starting in 2013 you were required to check the PDMP before filling a prescription, and at that time, you were getting very few calls that were initiated from pharmacies. Has that changed?

A. So let me just clarify my prior statement.

Starting in 2013, we set up requirements specifically in my clinic. It wasn't that it was a state mandate that we check the PDMP, but starting at that time -- and I supervise a lot of trainees, residents, and fellows -- it became a requirement in our clinic to check the PDMP before prescribing the controlled substance. It was not mandatory at the state level at that time. It didn't become mandatory in California until later.

Q. Do you recall when it became mandatory in California?

A. Yes. I believe it became mandatory in California in 2018 to have access to the PDMP and shortly after to check the PDMP prior to initiating a new prescription for a controlled substance.

Q. Okay. All right. Have you seen a change since 2013 in terms of the frequency that you would get calls, calls or electronic communications, communications through pharmacies about particular prescriptions that you or

your practice had written?
A. Yes. Particularly in the last couple of years, I have seen a much more heightened vigilance around opioid prescriptions on the part of pharmacists, and we have been getting more calls from pharmacists double checking red flags in the past couple of years.
Q. All right. And what are the most frequent red flags that pharmacists are identifying when they call where you practice if you are able to answer?
A. Yeah. So the most frequent kind of calls we have been getting or getting from pharmacists when they are concerned about a forged prescription, an illegitimate prescription or in the example I gave you, a patient calling in impersonating, potentially impersonating a prescriber.

Also, on Tuesday, I received a call from a pharmacist who was concerned about a case of doctor shopping. She had checked the PDMP prior to dispensing Sublocade, which I had prescribed for a patient.

It is an injectable form of buprenorphine and she had seen that he had received a hydrocodone prescription from not one but two other prescribers, but I was able to reassure her that he had had a recent surgery, and that the hydrocodone was appropriate in addition to the buprenorphine-Sublocade as a brief

analgesic in the context of his surgery and the fact that he had two prescribers was something that we had already seen and investigated and had confirmed that the one prescriber was covering for the other prescriber. It was not a case of doctor shopping.

I have had pharmacists call and tell me that the patient came in intoxicated and appeared to be under the influence, and that they were concerned about dispensing opioids or benzodiazepines to that individual. Those kinds of calls we would get.

Q. My last general question in this area: Are you able to quantify, you know, calls, inquiries from pharmacists on a weekly or a monthly basis, comparing the present, say, the last two years versus, you know, 2013-2014. I know you probably haven't kept detailed records but sort of from your recollection.

A. Yes. I can tell you in the first decade of this century I almost never received a call from pharmacists, and in fact, my first awareness of a patient of mine who was doctor shopping came to my attention because the insurance company sent me a letter expressing concern.

This was in the days prior to my having access or even knowing about the PDMP. This was in the early 2000s. I can think of a single instance between 2000 and 2012 or '13, in which I received a call from a

pharmacist who expressed concern about a patient who appeared to be intoxicated and about whom this pharmacist was concerned and felt uncomfortable dispensing --

Q. Okay. In the last --

A. -- compared to just this week I have already had two calls from pharmacists specifically relating to opioid prescribing and opioid dispensing.

Q. Okay. Couple more general questions, and then, I will take a break from mine and see if counsel want any follow-up.

Have you gained an understanding of the separate obligations of doctors and pharmacists regarding opioid prescribing and dispensing, and has your research and teaching included the role of pharmacies in the prescription-opioid epidemic?

A. Yes.

Q. Okay. If you can elaborate, please.

A. I am familiar with the Controlled Substances Act and the fact that every entity and individual in the supply chain has an independent and corresponding responsibility to prevent misuse and diversion and the harms caused by controlled substances.

Pharmacies and physicians, in particular, have an independent but corresponding responsibility that depends on their close communication and interaction with

each other to the extent that they are able afforded by the law.

These independent and corresponding responsibilities are vital because pharmacists and physicians have access to different kinds of information, and without all of those kinds of information, an individual who is misusing or diverting controlled substances could go undetected.

So for example, pharmacists have access to whether or not a patient is intoxicated or under the influence when they go to pickup their prescription. The pharmacist has access to information whether that customer paid in cash or traveled a far distance to pickup that prescription.

The pharmacist has information as to whether or not that individual is impersonating someone else or using a forged prescription. Those are all things I do not have access to.

Correspondingly, I have access to information the pharmacist doesn't have. I have a deeper and broader information of that individual's diagnosis, how they are presenting in clinical care, of their past history. I have access to labs: I have access to urine drug screens?

And another really important point regarding

this independent but corresponding responsibility between physicians and pharmacists is that physicians really only have access to the information based on one individual patient, whereas pharmacists, and more importantly, pharmacies have access to much more data than an individual physician might, including data about not just patients and their behavior patterns but also prescribers.

Pharmacies, for example, have access to data, which would allow them to know whether or not a certain prescriber is prescribing large quantities of a controlled substance prescribing in a pattern that is suggestive of a pill mill, and pharmacies could use this information and create tools to assist pharmacists in detecting red flags.

Q. Okay. Has your specific research in teaching included the role of pharmacies in mitigating or addressing the misuse of prescription opioids?

A. Yes.

Q. Okay. If you could elaborate on that, please?

A. So my research has delved into the disease of addiction, which gives me an understanding, an expertise in knowing the kinds of behaviors that people engage in when they become addicted and the kinds of manipulative techniques that they use?

And I write about that in my book "Drug Dealer, M.D." prior to being involved in litigation. I have researched and taught on prescription drug monitoring databases and the way that they can and should be used to monitor for misuse and diversion as well as the epidemiologic literature on the impact that checking the PDMP has had on opioid-related misuse addiction and overdose stats.

I have published on the PDMP and the importance of checking the PDMP, not just when red flags already exist, but even in cases that's in pristine precisely because a patient's outward appearance can be very different from their internal disease process?

And it is very difficult to really know patients' behaviors based on their outward appearance. We do need to check these objective data points, and the PDMP is one of the best tools we have. And I have written about the PDMP prior to being involved in this litigation, and I have researched, and I have taught on the PDMP.

So, you know, my research in my 25 years of clinical experience have given me the expertise and knowledge to be able to evaluate the pharmacies' policy and procedures for investigating red flags and have allowed me the expertise to determine whether or not

those policies and procedures were adequate.
Q. Let me just ask one more follow-up on that:
Have you studied the particular policies and procedures of any one of the Defendants in this case? So that would be the specific policies and procedures of Walgreens, CVS, Wal-Mart, Giant Eagle?
A. Yes, I have.
Q. Okay. Can you elaborate on that, please?
A. As detailed in my report, I studied the policies and procedures for investigating red flags and drug utilization review for each of the named pharmacy Defendants and followed how those policies and procedures changed over time, compared that to DEA enforcement actions and the peer-reviewed medical literature on which those regulations should be based and determined whether or not those policies and procedures for those individual pharmacy Defendants were adequate and sufficient to meet their corresponding responsibility according to the Controlled Substances Act.
Q. All right. Is this something you wrote about or you just studied? I mean, we will just say pick Walgreens, what your study of Walgreens' policies and procedures over time, is this something you wrote or just studied?
A. So my report has an entire section on Walgreens, not

just their policies and procedures, their good faith dispensing policy, but how it changed over time, how that compared to the information that was available and should have informed those policies and procedures and, furthermore, what kinds of tools they created to assist pharmacists in detecting red flags and, furthermore, what kind of road blocks they put in place, making it difficult, if not impossible, for pharmacists to do their due diligence and corresponding responsibility to detect red flags. And that's all in my report, your Honor.

Q. Okay. And what -- we will just stay with Walgreens because I assume you did the same thing for each Defendant, but let's just focus on Walgreens -- to do this, to generate this portion of your report sort of an examination over time of Walgreens' policies and practices and how they both assisted their pharmacists and in your opinion hindered their pharmacists, imposed road blocks on the individual pharmacists, tracking prescriptions, what exactly did you study or who did you contact to produce that?

A. Most of those documents were documents I obtained in discovery. I examined their good-faith dispensing policies and exactly what they identified as the roles and responsibilities of pharmacists, what they identified as red flags that should trigger pharmacists to

investigate.

I compared -- I looked at DEA enforcement actions that were occurring around the same time to determine whether or not their policies and procedures for detecting red flags were informed by DEA enforcement actions that were occurring, that should have informed those policies and procedures.

I investigated the medical literature on the risks, for example, of combining opioids and benzodiazepines and determined when in the medical literature it became known that that was a dangerous combination?

And their own policies dictate that the medical literature should inform how red flags are defined and what should be investigated and what pharmacists should investigate?

So I looked at whether or not they, in fact, utilized the medical literature and allowed that to inform their policies and procedures and the tools that they created for detecting red flags. I looked at things like their relationship with lobbying organizations, the National Association of Chain Drug Stores, for example, and how they interacted with and took the advice or didn't of those kinds of organizations.

I looked at consulting organizations that

they interacted with and how they took or didn't take the advice of those consulting organizations so basically looking in aggregate at all of the information that they had, that could have and should have informed their creation of policies to assist pharmacists.

Q. Okay. Thank you, Doctor.

THE COURT: I think I will take a break from my questioning and maybe no more than 10 minutes for each side to ask any follow-up in what I have asked.

So I think I will let the Defendants go first since it was your motion challenging Dr. Lembke. So who would like to question Dr. Lembke from the Defendants.

MR. BUSH: Your Honor, it is Graeme Bush from Zuckerman Spaeder. I don't know if you can see me?

THE COURT: Yes, Graeme, I see you.

MR. BUSH: I will be conducting the examination of Dr. Lembke for the defense, so I want to follow up on a couple of things.

EXAMINATION BY COUNSEL ON BEHALF OF DEFENDANT CVS

BY MR. BUSH:

Q. Dr. Lembke, good morning. It is almost as early for you as me. I am in the Mountain Time Zone.

A. Good morning.

Q. So one of the questions that Judge Polster asked you

related to your interaction with pharmacists, and I want to ask some follow-up questions in that area. One of the focuses of the questioning was whether your interactions related to particular prescriptions.

And in addition to that, there were some circumstances where information came to your attention and you under those circumstances were called upon to assist and about what kinds of information you could disclose beyond the particular prescription that you had written. Is that right?

A. Yes.

Q. Okay. So the interactions that you had, those related to the prescription. You did not conduct any kind of investigation about what other due diligence the pharmacists may have done before calling you or after calling you.

A. I am not sure I understand the question.

What do you mean by conducting an investigation for that individual pharmacist? Did I ask them what else they had done?

Q. When you're asking about a particular prescription, your are finding out what that pharmacist is interested in about that prescription, not what other due diligence the pharmacist may have done other than calling you?

A. No, that's not correct.

Q. All right.
A. These are often conversations between medical professionals where, again, to the extent that we are able, given privacy laws, where we share our information.
When the system is working as it should, we have a conversation about the patient and their prescription and the dispensing and where we have overlapping concern.
So that conversation might often entail other things that the pharmacist has observed or other information that the pharmacist has access to. You know, in instances when I can get that kind of information is incredibly helpful.
Q. All right. So one of the things you testified about has to do with your review policies and procedures?
A. Yes.
Q. And it is accurate, is it not, that the policies and procedures that you reviewed in connection with your report in this case are only the policies and procedures that were provided to you by Plaintiffs' counsel?
A. That is correct.
Q. And they were only the policies and procedures that related to the Defendants in this case?
A. Correct.
Q. And you are not able to make any comparison between

these policies and procedures of the Defendants in this case and policies and procedures that may or may not have been in place at other pharmacy companies?
A. Not beyond my own professional experience, interacting with pharmacists from different pharmacies.
Q. And you have not conducted any kind of systematic study or analysis of any pharmacy or pharmacy chain that isn't a Defendant in this case?
A. That's correct.
Q. And so the analysis of the policies and procedures that you have done in this case as an analysis, that was done specifically for the purpose of formulating opinions in this case?
A. As pertains to the evolution of policies and procedures for pharmacy Defendants over time, yes.
Q. You also testified about corresponding responsibility, and first of all, you are not a lawyer. That's right, correct?
A. That is correct.
Q. You would agree with me that the prescriber has a responsibility to write a prescription that is for a legitimate medical purpose in the usual course of his or her practice?
A. Yes.

Q. And the pharmacist has a different obligation called a corresponding responsibility to determine whether the doctor actually lived up to that obligation?
A. Well, that is part of the pharmacist's role, but the pharmacy, more broadly, has a responsibility to create policies and procedures to mitigate the risk of misuse and diversion and harm from dispensing.
Q. That's not in the language of the corresponding responsibility regulation, is it?
A. I believe that it is, if not in the CSA, certainly in many DEA enforcement actions.
Q. All right. And just to reiterate, you are not a lawyer?
A. No, I am not a lawyer.
Q. So I think only one other subject that I want to ask you some questions about, Dr. Lembke:

You have not had any -- actually withdrawn. Let me say it a different way.

You have not been involved in whatever training a pharmacist gets with respect to his or her corresponding responsibility. Is that right?
A. Can you clarify what you mean by "have been involved with"?
Q. Sure. You understand that pharmacists are trained or you believe that pharmacists are trained in

corresponding responsibility at pharmacy school?
A. Yes.
Q. But you haven't been involved in teaching any of those courses?
A. I have not been involved in teaching pharmacists in pharmacy school, no.
Q. And you haven't taken any of those courses?
A. No, I have not.
Q. And you haven't taken any continuing education courses that pharmacists might have with respect to their corresponding responsibility?
A. Well, I have to qualify that answer because much of the education that pharmacists have received in the past two decades regarding the legitimate use of opioids is similar to the education that physicians have received and has been influenced in a similar way by opioid manufacturers.

So in fact, I am familiar with education around opioids that pharmacists have received in the last two decades because it is very similar to the types of education received by physicians in the same time period.
Q. And if you haven't taken those courses, how do you know how similar it is or how dissimilar it is, Dr. Lembke?

A. Yeah, because that's part of the research that I have done, that I have investigated what those courses entailed, what kind of power points were used, what kind of educational messages were included in their curriculum. So I've looked into that.
Q. So do you recall that in your deposition at Track One -- and you know the difference between the tracks in these cases -- but I assume you know the differences?
A. Yes, I do. Thank you.
Q. Do you remember testifying that you knew that pharmacists had a certification and have schooling and a certification process, but you didn't know a whole lot more about it than that?
A. Yes. I specifically recall that testimony.
Q. And do you also recall that you are agreeing that you weren't a pharmacist in stating that you haven't studied what pharmacists go through?
A. Yes. And what I meant by that is, I don't know the specifics of pharmacy certification and education I don't know. Unlike my familiarity with medical training and physician training, I am not intimately familiar with the hoops that pharmacists jump through to get to be a pharmacist.
But I will add that medical education and pharmacy education is ongoing with continuing education

beyond pharmacy school, and that is the part of the pharmacists' education that I am familiar with and that I had studied and which, as I have said, has mirrored a physician education in the last two decades vis-a-vis opioids.

Q. Well, when you say it's your position, you have just also said that you agreed that you didn't know what pharmacists go through, and you don't know a whole lot more than they get a certification and have some schooling. So how can you have the kind of detailed information that you have just talked about?

And all I am talking here is specifically what pharmacists are trained in, not what they ought to be trained in.

A. I know that. I understand. Let me see if I can clarify.

So medical education, like pharmacy education, is long. It starts with school, and then you graduate, and you get your degree or your certification, and then you go out into practice? And in practice, there is a process of ongoing education that spans one's entire career.

When I said in prior deposition I was not familiar with pharmacist school and pharmacy education, it is just that. I am not familiar how pharmacists are

trained in pharmacy school, but after they graduate and are in practice and the recipient of different forms of education, I have studied that education around opioids, the education of, and I am familiar with the types of education that pharmacists have received, pharmacists who are working in pharmacies have received as part of they're maintenance of education or equivalency.

Q. So the answer that I asked you about before in Track One was in response to a question. What knowledge do you have about pharmacy training? It was not limited to pharmacy school. Do you recall that?

MR. WEINBERGER: Objection, your Honor.

A. Yeah --

THE COURT: I will let her answer the question. We are about at the end of the time.

MR. BUSH: And I am almost done, your Honor. I would be done anyway if you told me I was, but I am almost done, your Honor.

A. So my interpretation of the question at that time -- and I remembered it vividly -- was that I was being asked about pharmacy school, and I don't have much familiarity with pharmacy school.

So for example, I can tell you that physicians go to medical school. They get their license. They sit for their board. They have board certification.

I don't know what the various hoops are that pharmacists go through prior to becoming a pharmacist and working in a pharmacy. I don't know how long their school is. You know, I don't know what the tests are that they have to take.

So my answer has not changed, but I understood that question several years ago to pertain specifically to pharmacy school.

Q. I won't belabor the point, and I think the record will reflect what the questions were?

MR. BUSH: But with that, your Honor, I am done.

THE COURT: Thank you, Mr. Bush. Is there someone from the Plaintiffs who wants to ask follow-ups?

MR. WEINBERGER: Your Honor, this is Peter Weinberger on behalf of the Plaintiffs. I have no questions.

THE COURT: Okay. All right. Then I will go back to mine, Doctor.

FURTHER EXAMINATION BY THE COURT

BY THE COURT:

Q. I was asking you about your study of the prescribing practices and policies of each of the four Defendants, and you were describing that.

Was that study and research done only as part of your work as a -- as an expert in this litigation, or had you done some of that research before this litigation as part of your general research?

A. That research was primarily done since I have been involved in this litigation.

Q. Okay. That's what I figured, but I wanted to clarify.

As part of your research, either for this litigation or in general, have you looked into whether there exists any cooperative efforts between manufacturers and pharmacies to ensure access to prescription opioids for patients?

A. Yes.

Q. Okay. If you can describe what that has been, please?

A. In my research, I have found that pharmacy Defendants -- opioid manufacturers and opioid distributors collaborated together to promote opioids.

They did that through collaborative educational efforts of pharmacists, through collaboration around coupons and saving cards, through collaborations with direct-to-pharmacist advertising and also direct-to-patient consumer advertising so, for example, creating patient facing pamphlets, not just in

collaboration with manufacturers, but also in collaboration with pro opioid lobbying groups often funded by manufacturers.

Q. All right. I would like you to detail this a little more. What have you learned about these specific cooperative efforts with respect to education of pharmacists? How did the manufacturers of the pharmacies cooperate and collaborate in education of pharmacists and then coupon and saving card programs and then this advertising?

A. So pharmacy Defendants for a fee offered to promote and advertise specific opioid products to their pharmacists and also to patients.

Some pharmacy Defendants allowed, for example, Perdue drug reps to come into pharmacy stores and interact directly with pharmacy managers. Pharmacy Defendants collaborated with the American Pain Foundation and with the Pain Care Forum. These are loosely affiliated pro opioid lobbying groups largely funded by opioid manufacturers to, for example, create a patient facing pamphlet to, quote unquote, educate patients about the appropriate use of opioids in the treatment of pain.

Pharmacies worked together with opioid manufacturers to create so-called opioid super stores where opioids would be more readily dispensed without

questioning prescribers.
Q. Okay. Can you detail for me, explain to me what an "opioid super store" is? Is this a particular pharmacy, or is it something else?
A. It is a particular pharmacy at which opioids will be stocked in a way that makes them readily available to patients, but opioid super stores really go beyond that.

Some of these opioid super stores in my opinion became the equivalent of pharmacy pill mills where they promise opioid manufacturers, for example, not to question prescriptions but to make it guaranteed that a patient showing up there could get that prescription.

This was all done in the name of making sure that patients got opioids who needed them, but in fact, the volume of prescribing at these stores really suggests that there was misuse and diversion.

There was an instance in which one of the opioid manufacturers promised to resupply one of the pharmacies who had lost prescription -- lost some of their supply -- if they lost their supply through diversion. So even when there was known diversion, I have reviewed documents stating that pharmacy would be immediately resupplied.
Q. All right. Let me just pickup on that.

Was that particular pharmacy a pharmacy of

one of the Defendants in this case or some other pharmacy?
A. Yes, yes. And that's in my report, your Honor. I would be happy --
Q. Which company was this?
A. I believe it was Perdue, and I really would have to look at my report to see which pharmacy it was.
Q. But do you recall it was one of the Defendants in this case?
A. Yes.
Q. And these super stores that you've described, were any of -- any of these so-called super stores pharmacies of any of the Defendants in this case?
A. Yes.
Q. I guess I want to follow-up.

Have you examined, done any focused examination of the pharmacies operated by the four remaining Defendants in this case? That's Walgreens Wal-Mart, CVS, and Giant Eagle, pharmacies operated by those four Defendants in the two counties we are focusing on. The two Plaintiffs, as you know, are Trumbull County and Lake County, the Northeast part of Ohio.

Have you done any research on practices, policies of the pharmacies that the four Defendants operated in these two counties?

A. My research is based on national policies in aggregate. I have not looked at specific pharmacies in Lake and Trumbull County.
Q. All right. Have you formed a specific opinion based upon your medical knowledge and practice and the research you've done in this case as to whether the policies and practices of any of the four individual Defendants was sufficient and adequate to detect and ameliorate diversion of prescription overwrites? Have you formed an opinion?
A. Yes, I have.
Q. And is your opinion -- do you have a specific opinion as to each of the four Defendants?
A. Yes.
Q. All right. Is that opinion based on your research and your study of the literature and the documents?
A. Yes.
Q. All right. I guess I am going to ask you what that opinion is and do it by Defendant because again, as you know, in a court of law, the jury has to consider the evidence against each Defendant separately, and I would not allow anyone just to make a general blanket opinion undifferentiated and say, well, this applies to everyone and just a blanket opinion. That won't cut it in my Court, and I doubt any other one.

So let's start with Wal-Mart. What is your opinion on Wal-Mart?

MR. WEINBERGER: Your Honor, can I interject? Do you mind if Dr. Lembke refers to her report?

THE COURT: No, not at all, not at all.

BY THE COURT:

Q. And you know, I -- probably shorthand -- but I want to crystallize it, what her opinion is, and if you specifically state it in your report, you can highlight where it is in your report.

A. Well, my report includes all of the supporting evidence that contributed to my opinion. My opinion is that for each of the pharmacy Defendants individually they lacked policies and procedures to adequately investigate red flags during the first decade or more of the opioid epidemic, and even after certain policies were adopted, they were inadequate.

They could have and should have used their own data to assist pharmacies in identifying prescriber red flags and they furthermore more implemented counter-productive measures disempowering pharmacies from enacting their corresponding responsibility such as time limits and incentive programs.

Q. And this is all spelled out in your report?

A. Yes, by individual pharmacy Defendants.

MR. WEINBERGER: Your Honor, for purposes of the record, the report begins to address the specifics as to each of the Defendant pharmacies at page 99 and continues for about 20 or 25 pages thereafter.

THE COURT: Okay. Thank you, Mr. Weinberger.

BY THE COURT:

Q. And your last answer, you referred to the first decade.

A. First decade or more.

Q. Or more. What years are you talking about when you make that reference?

A. Approximately 1999 to approximately 2013-2015.

Q. So it is really closer to a decade and-a-half --

A. Yes.

Q. -- if you are using that time frame. Okay.

All right. I have to admit, I haven't read your report page by page.

Did you research, for example, whether the corporate practice required individual pharmacists to consult the PDMP before dispensing -- before filling a particular prescription?

A. Yes, your Honor. That was a specific focus of my research, and my report includes detailed chronology

around PDMP checking and what the corporate policy was regarding the PDMP in addition to studying OARRS, Ohio's PDMP, and what their regulations and policies were and how, in my opinion, regarding what pharmacy Defendants could have and should have done regarding requiring pharmacists to check the PDMP in order to fulfill their corresponding responsibility compared to what pharmacy Defendants actually did in that regard.

Q. Did your research and study and report include the policies, practices, and procedures with respect to identifying red flags and what, if any, checking should be done before the prescription would be filled?

A. Yes, your Honor. In detail in my report, I outlined what the, for example, pharmacy operation manuals, what the training, what the mandates were from the corporate level to individual pharmacists for each pharmacy Defendant regarding what they should be doing in checking for red flags as well as, your Honor, information on prohibiting pharmacists from taking certain actions that pharmacists themselves felt would be important for preventing --

Q. Can you elaborate on that?

What did you identify were examples of policy for pharmacists, for example?

A. For example, as I said before, what pharmacies have

access to, which physician prescribers do not, is prescriber level data, that is to say, which prescribers out there are essentially pill mill doctors issuing prescriptions not in the course of usual medical practice and not for a legitimate medical indication.

Pharmacists and pharmacies have access to that information; physicians do not. And there is evidence showing that pharmacy Defendant pharmacists at times wanted to have blanket refusals for dispensing for certain prescribers whom they had sufficient evidence to identify as pill mill doctors?

And they were prohibited by their higher ups in their pharmacies from doing that and told that they need to evaluate each prescription on an individual level when it comes, even in the case of known pill mill doctors.

So even though the pharmacy -- the pharmacists had the ability to look at that data and use that data to help pharmacists meet their corresponding responsibility, they did not do so.

Q. You have used the term "red flags," and I think you identified a few of them, and you gave examples.

How did you come up with your list of red flags?

A. My list of red flags is a combination of my clinical

experience, 25 years of seeing patients misusing and getting addicted to and diverting controlled prescription drugs. It is also based on DEA enforcement actions. It is also based on the peer-reviewed literature, for example, the evidence showing that combining benzodiazepines and opioids is a very dangerous combination?

And it is also based, in part, on the material produced by pharmacy Defendants themselves and their collaborators like the National Association of Chain Drug Stores, indicating a very acute awareness on the part of pharmacy Defendants about what they should be looking for and what constitutes red flags?

And my opinion is based on the large discrepancy between what pharmacy Defendants knew they could and should do and what they actually did to assist pharmacists in investigating red flags.

So for example, in my report, I talk about a meeting by the National Association of Chain Drug Stores, an organization to which the pharmacy Defendants in this case belonged and have National Association of Chain Drug Stores created a task force and said "we need to be more proactive about determining these red flags and investigating them."

And it outlined the three groups of red

flags that could be attributable to patient consumers, that could be attributable to prescribers, and that could be attributable to pharmacists, and they talked about the creation of a surveillance system, policies and regulations, that could detect these red flags?

And pharmacy Defendants in this case -- and I outlined one pharmacy Defendant in particular -- outright rejected the recommendations of their own organization.

Q. All right. As you know, there is no Government published list of red flags that say "look, these are the -- these are the things you must look for or check for."

My question is: In your research, your 25 years of clinical practice, research and study for this case, is there significant disagreement over what is and what isn't a red flag, or is it just -- are there a number of red flags, which almost everyone understands are suspicious and should be checked if my question is intelligible?

I just want to know, is there a consensus or is there disagreement, a significant majority and minority opinion?

A. Yes. I would say there are some red flags for which there is absolute clear consensus, no controversy whatsoever. I would add that red flags can emerge over

time. And so part of the responsibility of everybody in the opioid supply chain is to pay attention to emerging red flags?

And I would also assert that there can be some degree of controversy about a portion of those red flags and whether or not they constitute red flags or the extent to which they constitute red flags or how that red flag should be investigated.

Q. All right. I am about done.

I would like you to -- if you can identify the red flags that you say there is general consensus, that virtually everyone agrees that these things -- you have got to check for these things, or if you see one of these things you, are really being derelict if you don't do some follow-up or checking.

A. So, your Honor, I could do that from memory, but I might leave one or two things out.

Q. If you have identified it specifically in your report, that's fine.

A. Yes. I do identify it multiple places specifically in my report. I don't discuss in my report which red flags there is more consensus around than others. I don't do that.

It sounds like that's what you are asking me to do now.

Q. Right. I would like to know, if you can say, all right. Here are the five or ten consensus red flags that in your years of practice and your study and your research virtually everyone agrees that if you see something, one of these, you ought to start asking some questions.

A. Yeah. So I would say that consensus red flags -- and again, it is really important to keep in mind a red flag doesn't mean the pharmacist will not dispense. A red flag means this is something a pharmacist needs to investigate.

Q. Right. There may be a very good reason like the one you identified where you had a patient who had chronic pain but also had surgery, and that explained it.

So that's what we are talking about, something that needs checking.

A. So the consensus red flags are a patient who appears to be under the influence of a controlled substance at the time that they present to the pharmacy or for that matter to the prescribing doctor?

But specific to pharmacies and pharmacists, I think consensus red flags include traveling a significant distance to fill a prescription, paying in cash, behavior consistent with being under the influence.

Other patient-related red flags that have been described around which I believe there is consensus is large numbers of patients, you know, lining up in a pharmacy to get specific prescriptions, all of which have been written in the same way.

Consensus red flags, really a cross dispensing broadly is dangerous drug-drug combinations. So those dangerous drug-drug combinations often emerge over time. They are not necessarily known prior to, you know, the FDA approving that drug, but once they have been out in the market, they are detected to be a dangerous combination.

And then, many times the first alert comes from pharmacies and pharmacists and then trickles in the opposite direction to prescribers when they are alerted by pharmacists that it is a dangerous drug-drug combination, and specifically with opioids, that's benzodiazepines, sedatives, and opioids in combination, those -- because that's a commonly -- that's a combination that people who are addicted use and also because it is a deadly combination, because sedatives and opioids work synergistically to decrease heart rate, decrease respiration, and contribute to the increased overdose risk.

Those are often referred to as cocktails in

the DEA enforcement literature.

And then, other red flags from the pharmacy level are excessive volume and rate of growth of controlled substances at that pharmacy. You know, how to quantify a concerning rate of growth is -- there is probably some debate about that, but it is very clear that some pharmacies engaged in highly prolific dispensing outside of what could be appropriate medical use.

Q. All right. And --

A. Other ones -- I'm sorry.

Q. Do you know --

A. Sorry. Other ones include doctor shopping, so all of the kinds of red flags that you would get from checking the prescription drug monitoring database, doctor shopping, pharmacy shopping.

The PDMP is also very useful for dangerous drug-drug combinations because often patients will get a different prescription from different prescribers, so again, the individual prescriber may prescribe an opioid and not know that individual is also getting a benzodiazepine from somebody else or a stimulant from yet somebody else. There is Soma from their orthopedist, so checking the PDMP is really vital for assessing dangerous drug-drug combinations as well.

Q. Some of the red flags, many or most of the red flags, the consensus red flags you've identified are things that the individual pharmacist would be observing and should follow up and question.

Am I correct, you know, excessive volume and rate of growth of opioid prescriptions at a particular pharmacy, that would be something, would it not, that needs to be monitored at the corporate level because the problem there could be you have got an individual pharmacist that is just -- that's become a pill mill, and if that's the problem, obviously, the pharmacist will not be checking on herself or himself. Wouldn't that be something at the corporate you would see?

You have got 2,000 pharmacies over the country and you can see generally what percentage their business is prescription, opioids, and how it has changed over time, and if you have five or ten that seem off the charts, you ought to look.

Isn't that something that would need to be checked at the corporate level?

A. Your Honor, I would argue that all of these red flags need to be facilitated at the corporate level. It cannot be left to the individual pharmacist to independently check all of these red flags without support and tools created at the corporate level and

sufficient time granted at the corporate level. These are labor intensive investigations.

I think the average pharmacist has 1.5 minutes to fill a prescription. At the corporate level, if environment is not created to assist pharmacists in this work and the appropriate tools are not given to pharmacists and the appropriate guidance, then, that's not an adequate infrastructure for preventing misuse and diversion.

Q. Well, has your research, study, experience, identified what types of tools and support the corporation needs to give to its individual pharmacists to enable them to do their job?

A. That certainly is implied in my report, yes.

Q. You are saying it is implied. But I am not sure what that means. Have you detailed it in your report?

A. I have detailed in my report that pharmacists need to be given the time to investigate red flags. They need to be incentivized to investigate red flags. They are currently, commonly incentivized to dispense as many pills as possible in a given day, in the shortest amount of time to meet certain quotas or prom -- what's called promise times or bonus requirements.

They need to be given access to not just the

PDMP, which should be mandatory or required, in my opinion, for pharmacists to check prior to dispensing and which is labor intensive?

So they need to be given sufficient time and infrastructure and tools to check the PDMP, but also at the corporate level, the pharmacy Defendants have the ability to access their own databases to check red flags for prescribers, and pharmacists should not -- should also have access to that information.

And of course, their investigation around investigating red flags needs to be much more robust, informed by the literature, the scientific literature, informed by DEA enforcement acts.

There really isn't adequate policies and procedures or support of pharmacists in place in order to allow them to uphold their corresponding responsibility.

Q. Okay. Doctor, what do you think are the limits of your expertise with respect to the policies and dispensing practices of the four pharmacy Defendants?

A. I haven't done any quantitative analyses. I haven't looked at proportion of blame in any kind of quantitative way. I haven't specifically looked at individual pharmacies or pharmacists in Lake or Trumbull County.

Q. And I think, as Mr. Bush highlighted, you haven't

studied any of the other pharmacies which, of course, exist --

A. That's right, and I am not a lawyer, and I am not a pharmacist.

Q. -- and compared what, if anything, they are doing with the four Defendants here.

A. That's right.

Q. Do you believe there is a difference between a prescription that is not written for legitimate medical purpose and a prescription that is diverted, and if so, what would be the difference? So the difference between a prescription not written for legitimate medical purpose and a prescription that is diverted.

A. My understanding of diversion is that it is actions that allow a prescription to get into the hands of an individual for whom it was not intended. Sometimes a prescription that is not written for legitimate medical purpose can be an act of diversion.

Other times a prescriber who is well intentioned but duped might believe they are writing a prescription for a legitimate medical purpose when, in fact, that is not an evidence-based indication, or that prescriber may not have access to information that would allow them to make a judgment about whether or not that would be a legitimate medical purpose.

So I feel like those are overlapping venn diagrams.

Q. Let me see if I can flush this out a bit.

So if I have a condition that justifies a prescription opioid and my doctor examines me and prescribes that prescription to me and somehow that prescription gets to you, Doctor, and you fill it and you get the opioids, that's an example of a prescription that was written for a legitimate medical purpose but was diverted. Would that be fair?

A. Yes, assuming that the original prescription was for legitimate medical purpose.

Q. Right. Okay. I have a legitimate medical need for it, and the doctor believes I have a legitimate medical need, and he or she writes it for me, and the prescription ends up in your hands --

A. Uh-huh.

Q. -- and has been diverted. How it got diverted, that's an issue, but it is clearly diverted --

A. Yes.

Q. -- whereas if a prescription is written for me and, in fact, I don't have a legitimate medical need for that prescription opioid, that would be a prescription that is not written for a legitimate medical purpose, right?

A. That's right.

Q. There are many ways that that could come about, but that would be a prescription that is not written for a legitimate medical purpose.
A. That's right.
Q. And sometimes there is an overlap. You can have one but not the other. You could have both.
THE COURT: Okay. All right. I think that that covers what I wanted to cover, and we have got a few minutes. I guess, Mr. Bush, if you have a few follow-ups, and Mr. Weinberger, if you have any, and then we will be concluded.
MR. BUSH: Thank you, your Honor.

FURTHER EXAMINATION BY COUNSEL ON BEHALF OF DEFENDANT CVS

BY MR. BUSH:
Q. You testified, Dr. Lembke, I believe that a number of the policies and procedures that you've addressed in your report evolved over time. Do you recall that?
A. Yes.
Q. And you also said that red flags, some red flags evolved over time as well.
A. Yes.
Q. And with respect to the PDMP, I think you testified earlier this morning that the Stanford Clinic did not require consultation of the PDMP by the prescribers in

2013. Is my memory right on that?
A. Yes, that's right.
Q. Your opinion in this case, however, is that the pharmacy Defendants should have implemented a mandatory PDMP requirement much earlier than 2013, right?
A. I think in my report I do say that they should have made it mandatory. I believe that it should be mandatory for pharmacists. I can't remember what date I assigned to that, if any.
Q. Well, let me ask you some questions about the red flags that you went through in response to Judge Polster's questions.

You would agree, wouldn't you, that some of the red flags that you identified might not really be red flags because of what the pharmacist knows about the patient, knows about the Doctor, knows about the circumstances of the prescription that is being presented to that pharmacist?
A. Yes. I would agree with that.
Q. And you would agree that a pharmacist has an independent professional obligation and responsibility not to fill prescriptions that were not written for a legitimate medical purpose. Sorry for the double negative.
A. Yes.

Q. And likewise, individual pharmacists have a professional responsibility and a legal responsibility to comply with his or her corresponding responsibility?
A. I would agree with that, but what I emphasize in my report is that, if the corporate infrastructure is not in place to give the pharmacist the necessary tools to enact and uphold their corresponding responsibility, it becomes impossible for the pharmacist to do that.
Q. You also talked about and said something in the context of corporate action, but the pharmacist does have an incentive to live up to his or her professional obligations and legal obligations because if she doesn't, she could lose her license.
A. Well, part of the issue there is that pharmacists were miseducated about the evidence-based use of opioids by opioid manufacturers, collaborated with corporate pharmacy Defendants.

And so just as with doctors exercising their clinical judgment and their medical judgment requires having access to true information about legitimate medical use of opioids and having an infrastructure and environment that allows them to do that.

And there were significant, you know, my research showed me that there were significant consequences professional, adverse professional

consequences for pharmacists who complained about having inadequate time to safely dispense opioids and who, when suggesting, for example, that certain prescribers should have blanket refusals, that that was essentially rejected by corporate, and they were told that they had to continue to dispense.

So yes, in some ideal world, pharmacists would be able to exercise their judgment, but if their judgment isn't informed by the information and isn't supported by the environment that they live in, I don't think we can expect that pharmacists, except for a few martyrs, would be able to exercise that responsibility.

Q. If a pharmacist knew that a prescription was written by a doctor or another prescriber and it was not written for legitimate medical purpose, the pharmacist would have an incentive not to fill that prescription, regardless of any of the other information that you are talking about here because she could lose her license.

A. I disagree with your use of the word "incentive" there. I would say the pharmacist has a responsibility not to dispense, but in the face of all the other incentives from the corporate level, it can be very hard for the individual to go against the tide.

Q. Well, to go back to the PDMP for a second, I know

you've expressed some opinions about when pharmacy companies should have mandated that and under what circumstances pharmacy companies should have mandated their pharmacists consult a PDMP, but you have done no evaluation whatsoever to determine how often pharmacists at each of the pharmacy Defendants actually consulted the PDMP?

A. I haven't done any granular analysis at the individual pharmacist level, that's correct.

Q. Regardless whether or not the company had a policy that mandated it, it may well be the case that the pharmacist did consult the PDMP in appropriate circumstances?

A. In my 25-year clinical experience, the number of times I have detected red flags on the PDMP for my patients when the pharmacy did not is very high, so it has not been in my experience until the last couple of years that pharmacists are more regularly checking the PDMP, and the material that I've looked at would attest to that as well given that, uh-huh.

Q. Sorry. To my question though was whether you have in this case, in the two counties that are the Plaintiffs in this case, you haven't evaluated whether the pharmacists at the pharmacies, the pharmacy Defendants actually consulted the PDMP in appropriate circumstances.

You have not done that analysis.

A. Not at the individual pharmacy level, no.

Q. I want to generally stay away from individual Defendants in this examination, but I did want to ask you one question that was CVS specific.

And I don't know if I told you this at the outset, but I do represent CVS.

When you were -- this has to do with your opinions and testimony about what you consider to be cooperative efforts with the manufacturers and the distributors to enhance access to opioids. That's the general subject matter.

And you cited a variety of things that you believe showed collaboration, and you focused, as a result, I think, of Judge Polster's questions on super stores, but as I read the report, you have cited one document, an educational document that related to CVS, and that was the only thing you had cited to show CVS collaboration. And I want to ask you about that document.

It was an educational services document. It I think was produced by Incess, not by CVS and you characterized that document as "prescribing a promotional campaign that could be washed by CVS-Caremark pharmacies on behalf of selected opioid manufacturers, "and that

"this document illustrates that CVS-Caremark was in the business of promoting opioids, not just dispensing them."

Do you remember that general part of your opinion or generally remember that part of your opinion?

A. Yes.

Q. And I can pull that document up if you don't recall it, but do you have any evidence or information to suggest that there was ever an opioid product that was promoted pursuant to this educational program that CVS was talking about?

A. So my recollection of my report -- and I really need to look at my report to answer this question -- is that I cite more than one document. I cite a number of different documents around CVS' collaboration with Perdue, around the adherence program, CVS' collaboration with other pro opioid lobbying organizations. I am not specifically remembering that one document.

Q. I want to focus on that document if you don't remember it, and maybe we should just move on, but I would suggest to you that document doesn't say anything about opioids. It is a document that is generic. You don't have any --

THE COURT: That isn't productive, your characterization or conclusion.

MR. BUSH: All right. Well, then, I will pull it up, your Honor.

Can I do a sharer screen?

THE COURT: All right. We have only got a couple more minutes.

THE WITNESS: Can you tell me where in my report I cite the documents, so I can go to my report?

MR. BUSH: Tell you what. Let's just move on. As I said, I didn't want to really get into Defendant specific material.

It just struck me that that one was, in particular, an interesting use of the document. We will move on.

Let me see if I have anything else, your Honor.

THE COURT: Okay.

(Pause.)

MR. BUSH: That's all. I am done. Thank you, Dr. Lembke. I appreciate your time.

THE COURT: Okay. Thank you, Mr. Bush. Mr. Weinberger, anything you want to ask?

MR. WEINBERGER: Yes, your Honor, just a few questions.

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EXAMINATION BY COUNSEL ON BEHALF OF THE PLAINTIFFS
BY MR. WEINBERGER:
Q. Dr. Lembke, at page 112 of your report, you discuss the meeting convened by the National Association of Chain Drug Stores in January of 2013, which was entitled "DEA compliance working group." Do you recall that?
A. Yes.
MR. BUSH: I'm sorry. What was the page number? I didn't hear it.
MR. WEINBERGER: Page 112.
MR. BUSH: Thank you.
BY MR. WEINBERGER:
Q. In that report, you indicate that the working group included Walgreens representative as co-chair and representatives of CVS, Rite Aid, and Wal-Mart as participants. Do you recall that?
A. Yes.
Q. There is an exhibit in this case, which you've referenced, which is a chart created for that working group or by that working group of red flags. Do you see it? Do you recall that?
A. Yes. And I believe I did mention that in my testimony today.
Q. And those red flags are contained -- contain annotations to various DEA enforcement actions and other

sources. Is that true?
A. Yes.
Q. And it is broken down as you did by categories, patient conduct, physician conduct, and pharmacy conduct, correct?
A. Yes.
Q. And the annotations include DEA enforcement actions published in the Federal Register that go back as far as the late '90s. Is that correct?
A. Yes.
Q. And you reference some of those cases including the --
A. East Main Street document.
Q. Correct. That is dated back to 2010, correct?
A. Yes. Actually, I think the East Main Street is 2005-2006.
Q. You might be correct there.

Now, with respect to your testimony about the Ohio PDMP-OARRS -- and you couldn't recall the date that would be applicable to that PDMP as relates to the pharmacies' conduct -- if I could refresh your memory, although OARRS went into effect in 2006 in Ohio, in 2011, there was a regulation that required review of the OARRS-PDMP under certain circumstances by all pharmacists. Is that correct?

A. Yes. That was in 2011.
Q. Okay. When you check the PDMP at your Clinic, do you document your review of the PDMP and what was found?
A. Yes.
Q. The pharmacies are in the process in this case of producing their notes electronically as well as hard copy of notes pursuant to Court order for our review to determine what, if any, documentation was undertaken with respect to red flags and specifically with respect to checking the PDMP.

You have not had an opportunity to review those documents as of yet, correct?
A. No. But that would be tremendously useful.
Q. Okay. We are working on a deadline right now, but we will see what happens with that.

MR. WEINBERGER: Thank you, Dr. Lembke. Judge Polster, that's all I have.

THE COURT: All right. Thank you, Mr. Weinberger. All right.

I think we are concluded.

So Dr. Lembke, I appreciate it and again, thank you for taking the time away from your clinical practice and research and, candidly, your sleep because it is pretty darn early, although my guess is you start

your professional day early as we all do. Thank you.

This has been very helpful to me, to have this colloquy to better understand what you've done and the basis for your conclusions, so I can address the legal issues I need to.

So with that, we are adjourned and stay safe everyone, and I know we have a phone call in about 10 or 12 minutes calling in. So thank you very much. We are adjourned.

(Hearing concluded at 11:20 a.m.)

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C E R T I F I C A T E

I, George J. Staiduhar, Official Court Reporter in and for the United States District Court, for the Northern District of Ohio, Eastern Division, do hereby certify that the foregoing is a true and correct transcript of the proceedings herein.

s/George J. Staiduhar
George J. Staiduhar,
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